Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name
TPCIGA FOR RELIANCE NATIONAL INDEMNITY

Carrier's Austin Representative Box
Box Number 50

MFDR Tracking Number
M4-07-3806-01

MFDR Date Received
February 20, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the position of Renaissance Hospital that the respondent has not reimbursed theses services at a fair and reasonable rate as required in TDI-DWC rule 134.401… Our company has purchased national hospital payment data from 'Cleverly and Associates'; a nationally recognized company. This data is known as Med Par Data, based on this data, we have established a PAF or payment adjustment factor to be applied to our hospital specific Medicare OPPS reimbursement rate and determined this to be our interpretation and application of fair and reasonable…The PAF we have established is 213.83% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region."

Amount in Dispute: $7,324.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…according to Provider's billing, the claimant's stay at the hospital exceeded 23 hours and therefore, this admission meets the definition of an inpatient admission. Accordingly, reimbursement would be governed by the Acute Care Inpatient Hospital Fee Guideline… reimbursement in this case would be $1,118 for a one-day surgical stay plus additional reimbursement of $372.12 for the implant, at cost plus ten percent. Provider has already been reimbursed $2,236.00. Therefore, Provider is not entitled to additional reimbursement in this case."

Response Submitted by: Stone Loughlin & Swanson, LLP, One Northpoint Centre, 6836 Austin Center Blvd., Suite 280, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March17, 2006 to March18, 2006	Inpatient Hospital Services	$7,324.06	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the fair and reasonable reimbursement for services not identified in an established fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. THIS ITEM IS PACKAGED/BUNDLED INTO ANOTHER SERVICE/SURGICAL PROCEDURE PERFORMED ON SAME DATE, ADDITIONAL REIMBURSEMENT DISALLOWED.
   - 150 – PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE. DOCUMENTATION DOES NOT ADEQUATELY IDENTIFY/QUANTIFY SERVICES OR SUPPLIES BILLED.
   - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINES. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE. UNREASONABLY EXCESSIVE CHARGE.
   - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINES. REIMB BASED ON INSURANCE CARRIER FAIR AND REASONABLE. REIMBURSEMENT FOR THIS SERVICE HAS BEEN LIMITED TO A TWO DAY INPATIENT PER DIEM.
   - 150 – PMT ADJUSTED BECAUSE THE PAYER DEEMS THE INFO SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE. DOCUMENTATION REQUIRED TO REVIEW BILL.

Findings

1. The respondent's position statement asserts that "according to Provider's billing, the claimant's stay at the hospital exceeded 23 hours and therefore, this admission meets the definition of an inpatient admission." The Division's former rule at 28 Texas Administrative Code §134.401(b)(1)(B), effective August 1, 1997, Volume 22 *Texas Register*, page 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of the submitted documentation finds that the injured worker was admitted to surgery on March17, 2006 at 1300 hours. Review of the discharge records finds that the injured worker was discharged on March18, 2006 at 1320 hours. The submitted documentation supports that the length of stay exceeded 23 hours; the Division therefore concludes that the services in dispute are inpatient services.
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 836.0. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Texas Administrative Code §134.1, effective May 2, 2006, Volume 31 *Texas Register*, page 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3)

is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Our company has purchased national hospital payment data from 'Cleverly and Associates'; a nationally recognized company. This data is known as Med Par Data, based on this data, we have established a PAF or payment adjustment factor to be applied to our hospital specific Medicare OPPS reimbursement rate and determined this to be our interpretation and application of fair and reasonable…The PAF we have established is 213.83% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region."
   - Review of the submitted information finds that the data does not support the reimbursement amount sought by the requestor.
   - The requestor did not explain how it determined that a payment adjustment factor of 213.83% of the hospital specific Medicare Outpatient Prospective Payment System reimbursement rate would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that a payment adjustment factor of 213.83% of the hospital specific Medicare Outpatient Prospective Payment System reimbursement rate would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that this rate is consistent with most commercial and private payers in the region.
   - The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

	Grayson Richardson	July 20, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.